CHAPTER 9
SECTION 4

SPECIFIC DOUBLE COVERAGE ACTIONS

1.0. TRICARE AND MEDICARE

1.1. Medicare Always Primary To TRICARE

Certain persons *age* 65 years *and older* who were not previously entitled to Medicare Part A, "Hospital Insurance Benefits," became eligible to enroll in Part A after June 30, 1973, under the premium Health Insurance provision of the 1972 Amendment to the Social Security Act. Entitlement to Part A secured under these circumstances does not result in a loss of TRICARE benefits. With the exception of services provided by a *Federal Government facility*, in any double coverage situation involving Medicare and TRICARE, Medicare is always primary. When services are provided by a resource sharing provider in an MTF *to a beneficiary age 65 years and older, reimbursement shall be in accordance with the resource sharing agreement. No TFL funds are available for resource sharing within an MTF*.

1.2. Services Provided Prior to October 1, 2001

All services provided prior to October 1, 2001, on which Medicare is the primary payer are to be processed using the procedures described in Chapter 9, Section 3.

1.2.1. Coordination With Part A, Medicare

Virtually all Part A, Medicare, claims are submitted by participating providers. Because of the Part A payment mechanisms, the provider knows, at the time the claim is submitted, the amount that will not be paid by Medicare. This amount is then billed to the beneficiary or to the beneficiary's secondary coverage. It is this amount that TRICARE will pay along with any services denied by Medicare which are covered by TRICARE. In cases where the TRICARE allowable amount (or the negotiated rate) is less than the Medicare payment, the beneficiary will have no liability for the Medicare deductible and coinsurance. When the beneficiary has exhausted his or her Part A benefits for a benefit period, TRICARE will pay the full benefit amount for covered services.

1.2.2. Coordination With Part B, Medicare

With the exception of prescription drug claims, which are not a Medicare benefit, a TRICARE claim must be accompanied by a copy of the appropriate Explanation of Medicare Benefits (EOMB) form. When Medicare paid its benefits directly to the beneficiary, the secondary share paid by TRICARE will be calculated according to the procedures in Chapter 9, Section 3, paragraph 2.0. When Medicare paid benefits directly to the provider, TRICARE may pay only the Medicare deductible, if any, the Medicare coinsurance, and any services which were denied by Medicare and which are covered by TRICARE. In cases where the TRICARE allowable amount (or the negotiated rate) is less than the Medicare payment, the

beneficiary will have no liability for the Medicare deductible and coinsurance. TRICARE may not pay the difference between the billed charge and the Medicare allowed charge, since to do so would place the provider in violation of Medicare's assignment agreement.

1.3. Services Provided On or After October 1, 2001

As of October 1, 2001, TRICARE beneficiaries who become entitled to Medicare Part A, based on age, do not lose TRICARE eligibility if they are enrolled in Medicare Part B. Special double coverage procedures are to be used for these claims in order to minimize out-of-pocket expenditures for these beneficiaries. These special procedures are to be used for all claims for beneficiaries who are eligible for Medicare, including active duty dependents who are age 65 and over as well as those beneficiaries under age 65 who are eligible for Medicare for any reason. The following sections set forth the amounts that TRICARE will pay if the beneficiary is covered by Medicare and TRICARE. If a third coverage is involved, TRICARE will be last payer (see the Policy Manual, Chapter 13, Section 12.1) and payments by the third coverage will reduce the amounts of TRICARE payment that are set forth below. In all cases where TRICARE is the primary payer, all claims processing requirements (such as application of TRICARE Claimcheck) are to be followed. TRICARE benefits shall be extended to beneficiaries who become entitled to Medicare prior to October 1, 2001 and who have a date of admission before October 1, 2001 whose admission continues on or after October 1, 2001, when the institution bills based on DRGs. Additionally, in following the TRICARE/CHAMPUS Policy Manual Chapter 13, Section 6.1B, when a beneficiary becomes eligible for Medicare during any part of his/her inpatient admission, the hospital claim shall be submitted to Medicare first and TRICARE/ CHAMPUS payment (using at-risk funds) will be determined under the normal double coverage procedures.

1.3.1. Services that are a benefit under both Medicare and CHAMPUS

1.3.1.1. *If the service or supply is a benefit under both Medicare and TRICARE, the beneficiary will have no out-of-pocket expense. For these claims TRICARE will resemble a Medicare supplement. That is, the allowable amount under Medicare will be used as the TRICARE allowable, and TRICARE payment will equal the remaining beneficiary liability after Medicare processes the claim without regard to any TRICARE deductible and cost-share amounts that would otherwise be assessed. For example, if it is the first claim of the year and the billed charge is $50 (which is also the amount both Medicare and TRICARE allow on the claim), Medicare will apply the entire amount to the Medicare deductible and pay nothing. In this case, TRICARE will pay the full $50 so that the beneficiary has no out-of-pocket expense. Similarly, if Medicare pays an amount that is greater than what TRICARE normally would allow for a network provider, TRICARE will still pay any Medicare deductible and cost-sharing amounts, even if that represents payments in excess of the normal TRICARE allowable amount.*

NOTE: *It is not necessary for the contractor to price these claims, since the Medicare allowable becomes the TRICARE allowable, and TRICARE payment is based on the remaining beneficiary liability. The contractor need only verify eligibility and coverage in processing the claim. Contractors will not be required to duplicate Medicare's provider certification, medical necessity, referral, authorization, and potential duplicate editing.*

1.3.1.2. *If the service or supply normally is a benefit under both Medicare and TRICARE, but Medicare cannot make any payment because the beneficiary has exhausted Medicare benefits,*

TRICARE will make payment as the primary payer assessing all applicable deductibles and cost-shares. For example, TRICARE is primary payer for inpatient care beyond 150 days.

1.3.1.3. *If the service or supply normally is a benefit under both Medicare and TRICARE, but Medicare cannot make any payment because the beneficiary receives services overseas where Medicare will not make any payment, TRICARE will process the claim as a primary payer with any applicable deductibles and cost-shares. Since the contractor knows that Medicare cannot make any payment on such claims, the contractor can process the claim without evidence of processing by Medicare. Even though Medicare cannot make payment overseas, beneficiaries receiving care overseas must still purchase Part B of Medicare in order to maintain their TRICARE eligibility.*

1.3.1.4. *If the service or supply normally is a benefit under both Medicare and TRICARE, but Medicare does not make any payment because the service or supply is not medically necessary, TRICARE cannot make any payment on the claim. In such cases, the contractor is to deny the claim. The beneficiary/provider must file an appeal with Medicare. If Medicare subsequently reverses its medical necessity denial, Medicare will make payment on the claim and it can then be submitted to TRICARE for payment of any remaining beneficiary liability. If Medicare does not reverse its medical necessity denial, the claim cannot be paid by TRICARE.*

1.3.2. Services that are a benefit under Medicare but not under TRICARE

TRICARE will make no payment for services and supplies that are not a benefit under TRICARE, regardless of any action Medicare may take on the claim.

1.3.3. Services that are a benefit under TRICARE but not under Medicare

If the service or supply is a benefit under TRICARE but not under Medicare, TRICARE will process the claim as the primary payer assessing any applicable deductibles and cost-shares. If the contractor knows that a service or supply on the claim is not a benefit under Medicare, the contractor can process the claim without evidence of processing by Medicare for that service or supply.

1.3.4. Services that are provided in a non-DoD government facility

If services or supplies are provided in a TRICARE authorized non-DoD government facility, such as a Veterans Administration Hospital pursuant to the Policy Manual, Chapter 10, Section 1.1, Medicare will make no payment. In such cases TRICARE will make payment as the primary payer assessing all applicable deductibles and cost-shares.

NOTE: *In order to achieve status as a TRICARE authorized provider, Veteran's Administration facilities must comply with the provisions of the Policy Manual, Chapter 10, Section 1.1.*

1.3.5. Services provided by a Medicare at-risk plan

If the beneficiary is a member of a Medicare at-risk plan (for example, Medicare Plus Choice), TRICARE will pay 100% of the beneficiaries co-pay for covered services. A claim containing the required information must be submitted to obtain reimbursement.

1.3.6. Beneficiary Cost Shares

Beneficiary costs shares shall be based on the network status of the provider. Where TRICARE is primary payer, cost shares for services received from network providers shall be TRICARE Extra cost shares. Services received from non-network providers shall be TRICARE Standard cost shares. Network discounts shall only be applied when the discount arrangement specifically contemplated the TFL population.

1.3.7. Application of Catastrophic Cap

Only the actual beneficiary out-of-pocket liability remaining after TRICARE payments will be counted for purposes of the annual catastrophic loss protection.

2.0. TRICARE AND MEDICAID

Medicaid is not considered a double coverage plan. When a TRICARE beneficiary is also eligible for Medicaid, TRICARE is always primary for all classes of beneficiary. If Medicaid erroneously pays benefits as a primary payor on behalf of a TRICARE beneficiary, the contractor will reimburse the state Medicaid agency. See the Policy Manual, Chapter 13, Section 5.1.

3.0. MATERNAL AND CHILD HEALTH PROGRAM/INDIAN HEALTH SERVICE

Eligibility for health benefits under either of these two Federal programs is not considered to be double coverage. (See the Policy Manual, Chapter 13, Section 12.1.)

4.0. TRICARE AND VETERANS ADMINISTRATION

Eligibility for health care through the Veterans Administration for a service-connected disability is not considered double coverage. The beneficiary may choose to use either TRICARE or Veterans benefits, providing he/she is TRICARE eligible. (The VA sponsor of a TRICARE beneficiary is not eligible for care under either TRICARE or CHAMPVA.) However, TRICARE will not duplicate payments made by or authorized to be made by the Veterans Administration for treatment of a service-connected disability.

5.0. TRICARE AND WORKER'S COMPENSATION

TRICARE benefits are not payable for work-related illness or injury which is covered under a Worker's Compensation program. The TRICARE beneficiary may not waive his or her Worker's Compensation benefits in favor of using TRICARE benefits. The beneficiary must apply for Worker's Compensation benefits. Failure to apply does not change the TRICARE exclusion.

5.1. Review Of Claims

5.1.1. If the claim indicates that an illness or injury might be work-related, the contractor must develop to determine whether the beneficiary has applied for Worker's Compensation. If the beneficiary has applied but a determination has not yet been made, see paragraph 5.4. below. If the beneficiary has not yet applied, the contractor will explain the requirement to do so and will deny the claim.

5.1.2. The beneficiary must be told that the claim may be resubmitted if the Worker's Compensation claim is denied or if there is an extensive delay in the determination. If the Worker's Compensation claim is denied, the TRICARE contractor will process the claim routinely. When necessary, the TRICARE contractor will coordinate with the Worker's Compensation agency to establish the status of a Worker's Compensation claim.

5.2. Dispute As To Work-Related

The agency which has authority to determine "work-related" illness or injury in a case (as designated by the applicable Worker's Compensation law) is the final authority in all such determinations. If a disputed case is determined not to be work related (i.e., a substantive determination rather than a decision that Worker's Compensation benefits are not payable for technical reasons), TRICARE shall assume liability for extension of benefits.

5.3. Exhaustion Of Worker's Compensation Benefits

If a TRICARE beneficiary exhausts available Worker's Compensation benefits, TRICARE will provide benefits for covered services. The beneficiary must furnish written documentation to the contractor that the Worker's Compensation benefits have been exhausted.

5.3.1. Lump-Sum Settlement

If the Worker's Compensation benefits were paid in the form of a lump-sum settlement, TRICARE will not pay benefits for the work-related illness/injury until the beneficiary furnishes written proof that he or she has incurred medical expenses equal to the amount of the award designated for medical expenses. If the award was not distributed specifically between medical expenses and damages, the beneficiary must furnish proof that he or she has incurred medical expenses equal to the full amount for the award. (The incurred medical expenses need not represent TRICARE covered services if they are related to the work-related illness or injury.)

5.4. Special Assistance For Extensive Delays

The contractor should extend benefits in Worker's Compensation cases which involve an extensive delay by the state agency in reaching the Worker's Compensation determination. Benefits may also be paid when an unusual delay occurs because the beneficiary elects to appeal an adverse decision by the Worker's Compensation agency. If the beneficiary makes a request for this special assistance, the contractor should obtain an agreement from the Worker's Compensation agency that the agency will reimburse it for any benefits paid, up to the amount of the award, in the event of a determination that the beneficiary is entitled to Worker's Compensation benefits.

6.0. TRICARE AND SUPPLEMENTAL INSURANCE PLANS

6.1. Not Considered Double Coverage

Supplemental or complementary insurance coverage is a health insurance policy or other health benefit plan offered by a private entity to a TRICARE beneficiary, that primarily is designed, advertised, marketed, or otherwise held out as providing payment for expenses

incurred for services and items that are not reimbursed under TRICARE due to program limitations, or beneficiary liabilities imposed by law. TRICARE recognizes two types of supplemental plans, general indemnity plans and those offered through a direct service health maintenance organization (HMO). Supplemental insurance plans are not considered double coverage. TRICARE benefits will be paid without regard to the beneficiary's entitlement to supplemental coverage.

6.2. Income Maintenance Plans

Income maintenance plans pay the beneficiary a flat amount per day, week or month while the beneficiary is hospitalized or disabled. They usually do not specify a type of illness, length of stay, or type of medical service required to qualify for benefits, and benefits are not paid on the basis of incurred expenses. Income maintenance plans are not considered double coverage. TRICARE will pay benefits without regard to the beneficiary's entitlement to an income maintenance plan.

6.3. Other Secondary Coverage

Some insurance plans state that their benefits are payable only after payment by all government, Blue Cross/Blue Shield and private plans to which the beneficiary is entitled. In some coverages, however, it provides that if the beneficiary has no other coverage, it will pay as a primary carrier. Such plans are double coverage under TRICARE law, regulation and policy and are subject to the usual double coverage requirements.

7.0. SCHOOL COVERAGE - SCHOOL INFIRMARY

TRICARE benefits shall be paid for covered services provided to students by a school infirmary provided that the school imposes charges for the services on all students or on all students who are covered by health insurance.

8.0. TRICARE AND PREFERRED PROVIDER ORGANIZATIONS

See the Policy Manual, Chapter 13, Section 10.1.

9.0. DOUBLE COVERAGE AND THE PROGRAM FOR PERSONS WITH DISABILITIES (PFPWD)

9.1. Program for Persons with Disabilities claims are subject to double coverage provisions. If a Program for Persons with Disabilities (PFPWD) beneficiary is eligible for other federal, state, or local assistance to the same extent as any other resident or citizen, TRICARE benefits are payable only for amounts left unpaid by the other program, up to the TRICARE maximum of $1,000 per month. The beneficiary may not waive available federal, state, or local assistance in favor of using TRICARE.

10.0. PRIVATELY-PURCHASED, NON-GROUP COVERAGE

Privately-purchased, non-group health insurance coverage is considered double coverage.

11.0. LIABILITY INSURANCE

If a TRICARE beneficiary is injured as a result of an action or the negligence of a third person, the contractor must develop the claim(s) for potential third party liability (TPL). (See Chapter 11, Section 5.) The contractor shall pursue the Government's subrogation rights under the Federal Medical Care Recovery Act, if the other health insurance, including auto or home owner's medical insurance, no-fault auto, or uninsured motorist coverage does not cover all expenses.

12.0. TRICARE AND PRE-PAID PRESCRIPTION PLANS

If the beneficiary has a "pre-paid prescription plan," where the beneficiary pays only a "flat fee" no matter what the actual cost of the drug, the contractor shall cost-share the fee and not develop for the actual cost of the drug, since the beneficiary is liable only for the "fee."

13.0. TRICARE AND STATE VICTIMS OF CRIME COMPENSATION PROGRAMS

Effective September 13, 1994, State Victims of Crime Compensation Programs are not considered double coverage. When a TRICARE beneficiary is also eligible for benefits under a State Victims of Crime Compensation Program, TRICARE is always the primary payer over the State Victims of Crime Compensation Programs.

14.0. SURROGATE ARRANGEMENTS

Contractual arrangements between a surrogate mother and adoptive parents are considered Other Coverage. If brought to the contractor's attention, the requirements of Chapter 11, Section 5, paragraph 2.10. would apply.